MPP

Maryland Pharmacy Program
Eligibility Application

State of Maryland - Department of Health and Mental Hygiene

The **Maryland Pharmacy Program** (MPP) is a federally approved Medicaid waiver program that helps eligible Maryland residents pay for medically necessary prescription drugs. Applicants must be 19 years of age or older, not eligible for Medicare, and a U.S. citizen or a qualified alien who meets all requirements for benefits.

There is no fee to enroll, no deductibles, no monthly premium, and no annual benefit limit. There is a small co-payment for each prescription.

Because income/asset limits and co-pays are subject to change, please see our website, WWW.DHMH.STATE.MD.US or call 1-800-226-2142 for the most current information. TDD for Disabled – Maryland Relay Service 1-800-735-2258.

Important Application Information and General Instructions

- **Read** all the instructions for each part before filling it out.
- **Print** clearly. All information must be readable.
- You **must answer all questions**. Do not leave any blank spaces. Put a "**0**" or "**NA**" in each space that does not apply.
- You must include written proof documentation of all requested information such as Social Security number, lawful immigration status, and work history.
- You must include written proof for all income and assets.
- Send copies of documentation only. Original documents will not be returned.
- If you have little income or assets, the person or agency providing your food and shelter must submit a supporting statement.
- Applications will NOT be accepted via email or fax.

When finished:

Please remove and mail the application page and proofs to:

MPP
P.O. Box 386
Baltimore, MD 21203-0386

Revised January 2006

Instructions for Completing MPP Application

Important: Print with black or blue ink or type in the required information

A. Print your First Name, Middle Initial and Last Name.

B. You must list a complete home address for where you live. If you are homeless, please write "homeless" in the home address line and fill in the county and state. Please list your home phone, including area code.

C. If you have a Post Office box to get mail, list it here. If you want a **representative** or someone else to get your mail, put that person's name and address in the mailing address box. You can include a message phone number here.

D. Circle your current living arrangement.

E. Circle your current marital status. Submit a copy of separation/divorce decree, including any alimony and/or child support.

F. List yourself, your spouse, and all sons and daughters (under 19) living with you. Children 19 and older must apply separately.

- Children under 19 years old must be listed to determine family size. However, children are not eligible for the Maryland Pharmacy Program (MPP) unless they have been denied by the Maryland Children's Health Program (MCHP).
- Please list additional sons and daughters (under 19), with all information, on a separate sheet.
- Social Security numbers are only used to identify applicants and to help verify total household income. Persons not applying for benefits are not required to provide a SS number.
- List the relation of each person to you, such as spouse, son, daughter, stepchild or adopted. Grandchildren, foster children, or other relatives are not counted as part of your household.
- You may list more than one race for each person. Current choices approved by Federal regulations are: Asian, African American, Caucasian, Native American, and Pacific Island-Alaskan.
- You may enter your ethnic group, such as Latino or Hispanic, for statistical purposes
- Please check Male or Female to indicate sex.
- Applicants must check YES or NO for U.S. Citizen. If **NO** send proof of alien status from the Immigration and Naturalization Services (INS) that includes the date the applicant became a **permanent** alien resident and the alien registration number.
- Please check YES or NO next to **applicant** to let us know who wants pharmacy benefits.

G. Primary Language is included to help provide an interpreter if needed.

H. Persons eligible to apply for Medicare Part "D" (pharmacy benefits) are not eligible for the Maryland Pharmacy Program. However, a non-Medicare spouse may receive MPP benefits.

I. Please complete appropriate sections for visually or hearing impaired.

MARYLAND PHARMACY PROGRAM APPLICATION

A	First Name	MI	Last Name		Phone Number ( )	
B	Home Street Address (Include Apt)		City	ST	Zip	County
C	Mailing Name & Street Address or P.O. Box(If different or for a representative)					
	City	ST	Zip	Message Phone( )		
D	**Living Arrangement** (*Circle One*)	At Home Nursing Home/LTC Assisted Living Homeless Correctional Facility Migrant Camp Other: _____				
E	**Current Marital Status**: (*Circle One*)	Never Married Married Separated Divorced Widowed				
F	**Please read the instructions for section F before completing.**					

		Self	**Spouse**	**Child**	**Child**
	First Name				
	Last Name				
	Social Security #				
	Date of Birth				
	Relation to applicant	SELF			
	Race				
	Ethnic Group.				
	Gender	☐ Male ☐Female	☐ Male ☐Female	☐ Male ☐Female	☐ Male ☐Female
	U.S. Citizen?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Applicant ?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

G	Family's Primary Language:_____	Do you need an interpreter? ☐ Yes ☐ No
H	If you and/or your spouse have Medicare, write your and/or your spouse's complete Medicare claim number(s) as it appears on your Medicare card(s) on the lines below. Medicare Claim Number(s)_____ (Applicant) _____ (Spouse)	
I	Are you or any other household member visually impaired? ☐ Yes ☐ No If yes, do you want large print notices? ☐ Yes ☐ No Are you hearing impaired? ☐ Yes ☐ No (If Yes, do you need an interpreter?)	

Please Turn Page and Complete The Other Side

MPP FINANCIAL INFORMATION

Income	Self	How Often	Spouse	How Often	Children	How Often
Social Security	$		$		$	
Widow's Pension	$		$		$	
SSI or SSDI	$		$		$	
Railroad Retirement	$		$		$	
Black Lung Benefit	$		$		$	
Federal Civil Service	$		$		$	
Pension / Retirement	$		$		$	
Veteran's Benefit	$		$		$	
Unemployment	$		$		$	
Workers Compensation	$		$		$	
Insurance Benefit	$		$		$	
Interest / Dividends	$		$		$	
Trust Annuity	$		$		$	
Wages	$		$		$	
Self Employment	$		$		$	
Other Income	$		$		$	

Assets	Self	Spouse	Children
Checking	$	$	$
Savings / CD	$	$	$
IRA / Keogh	$	$	$
Stocks / Bonds	$	$	$
Real Property	$	$	$
Trust Fund	$	$	$
Other	$	$	$

Do you have other insurance, including **Medicaid** that pays for medicine? ☐ Yes ☐ No
If yes, please write the name of the insurance company or program and your ID/ policy number.

Are you suing or have you won a lawsuit to recover medical care costs? ☐ Yes ☐ No

I have read and agree to the rights and responsibilities listed elsewhere in this application packet. Everything in this application is true and complete to the best of my knowledge.

Applicant's Signature _____ Date __/__ /__ Spouse's Signature _____ Date __/__/ ___

Representative's Signature, if applicable	Date ___/ __ /___	**Internal Use Only**

INSTRUCTIONS FOR COMPLETING FINANCIAL SECTION INCOME

YOU MUST ANSWER ALL QUESTIONS. DO NOT LEAVE ANY BLANK SPACES. PUT A "0" OR "NA" IN EACH SPACE THAT DOES NOT APPLY.

INCOME

1. List the **GROSS** amount (**before any deductions**) and frequency of **all** income for all members of the household.

2. You must submit a copy of a **current benefit statement** from the agency or company that sends you the money.

3. If you receive more than one Social Security benefit you must list both.

4. If you receive **SSI** or **SSDI**, please **circle** which one(s) you receive. We count these incomes differently.

5. You must submit **the most current statement** of payments of dividends, trusts, annuities, and all other incomes listed.

6. If you are working, you must submit **complete** copies of four (4) most recent and consecutive pay stubs or a signed statement, on letterhead, from your employer giving this same information or expected earnings for the next six (6) months. Wages include all money you get for a job, tips, and commissions. Failure to do this will result in a delay in your application.

7. If you are **not** currently working, but have worked in the **last six (6) months**, you must **submit a statement** from your former employer giving your last day worked, **or** proof that you have applied for unemployment.

8. If you are **self-employed**, you must submit a **signed copy** of your latest **tax return and schedule C** showing business profit or loss.

9. **Other Income** includes things like alimony, child support, rent paid to you, money received on a regular basis, etc. Please list the type of income as well as the amount and frequency. You must submit supporting documentation such as receipts, child support enforcement forms, or a letter from the person giving you the money.

10. If you have little or no income, the person or agency providing your food and shelter must submit a supporting statement.

ASSETS

1. List the value of all assets for all members of the household. You must submit a current statement from your bank or other institution showing the amount and ownership of the asset.

2. Do not list the home you live in. Submit the property tax statement of any other real property you own, either by yourself or with others.

3. **Checking, CDs, IRAs, Keoghs**, and other **savings** accounts are assets and must be listed and proof must be sent. This includes any direct deposit accounts.

4. Trust funds are counted as an asset, unless you submit proof that you do not have access to it.

PLEASE REMEMBER TO SIGN AND DATE YOUR APPLICATION. AN UNSIGNED APPLICATION IS NOT VALID AND WILL BE RETURNED. A REPRESENTATIVE MAY SIGN ONLY IF THE APPLICANT IS PRESENT AND UNABLE TO SIGN.

MPP RIGHTS AND RESPONSIBILITIES

Please read and save these rights and responsibilities for your records.

I understand and agree to the following:

A. This application constitutes a request for the Maryland Pharmacy Program only.

B. My Social Security number will be used to verify identity and eligibility. My Social Security number may also be used to cross-match information in federal, state, and local government files.

C. The Department may conduct independent verification of the statements made by me on this application.

D. I must notify the Department within 10 days of any changes in the household income or assets. I must also notify MPP of a change of address or living arrangements.

E. I understand that the information given on this form is confidential and will only be used for the purpose of program administration.

F. I have the right to appeal any decision made concerning my eligibility or benefits.

G. I certify that everyone requesting benefits is a U.S. citizen or qualified alien.

H. I am required by law to assign to the State all third party payments and to cooperate with the state in securing such payments.

I. The State may recover monies from the estate of individuals over 55 years old who received program benefits and who do not have a living spouse or a surviving child who is under 21 or blind or disabled.

J. I agree to the release of personal and financial information from any financial institution, insurance company, present or past employer, federal, state or local governmental agency, private or public organization to the Department for eligibility determination.

K. The Maryland Pharmacy Program will not permit inspection of your personal information, or make it available to others, except as permitted by federal and State law.

YOUR APPLICATION MUST BE <u>COMPLETE</u> AND <u>SIGNED</u> OR THE DECISION IN YOUR CASE WILL BE DELAYED. IF YOU HAVE QUESTIONS, CALL OUR OFFICE AT 1-800-226-2142 <u>BEFORE</u> YOU SEND YOUR APPLICATION.